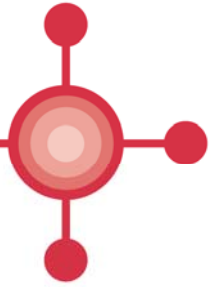


All Wales Medicines Strategy Group

Grŵp Strategaeth Meddyginiaethau Cymru Gyfan



# All Wales Review and Guidance for Prescribing Intervals

February 2013



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## 1.0 RECOMMENDATIONS

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- A 28-day repeat prescribing interval is broadly recommended; however, discretion should be used for individual patients or medicines. This should be coupled with a rigorous and effective medication review process.
- Repeat prescribing systems that promote synchronised, once per month requests for long-term medication should be developed.
- People that are stabilised on their medicines and are suitable for longer prescribing intervals can be considered for repeat dispensing (28-day prescriptions for 6–12 months).
- However, due to low uptake and other issues highlighted in this paper, a robust evaluation of the Repeat Dispensing Scheme in Wales would ensure that resources are being spent appropriately and will guide a decision on the future of the service.
- Prescribers should consider a flexible approach when initiating a medicine; a shorter interval (7–14 days) may be appropriate initially to assess tolerability and compliance, or may be recommended by the BNF or regulatory bodies.

## 2.0 BACKGROUND

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28-day prescribing within primary care was included as an Annual Operating Framework (AOF) target of NHS Wales in 2010–2011 as part of the Productivity and Efficiency measures, along with a target for repeat dispensing. Repeat dispensing is a service under the community pharmacy contract whereby GPs can print out up to 12 prescriptions at once to be dispensed at appropriate intervals by a community pharmacist (equivalent to up to 12 months of treatment)<sup>2</sup>. Repeat dispensing provides pharmacists with a number of opportunities for a discussion with the patient to determine whether they still require the medicine, and whether the patient is experiencing any problems with taking it. Feedback from areas that have implemented repeat dispensing is that patients find the system more convenient<sup>3</sup>.

## 3.0 28-DAY INTERVALS VERSUS “APPROPRIATE” SUPPLY INTERVALS

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A 28-day prescribing interval has been promoted across the UK, primarily to reduce waste from unused medicines. A literature search was undertaken to identify papers addressing prescribing intervals. The literature search did not support a definitive position, and the recommendations made are a consensus position of the All Wales Prescribing Advisory Group (AWPAG) following consultation with stakeholders.

One of the earliest references to a 28-day prescribing cycle is from a 1996 Yorkshire study, estimating that there would be a 34% reduction in the cost of waste medication by changing the prescription duration to 28 days, with a linear correlation between mean values of returns and prescription length<sup>4</sup>. Other audits, studies and reports have supported a link between increased prescribing intervals and increased waste<sup>5,6</sup>.

It has been argued that the evidence supporting waste reduction from a 28-day prescribing interval is not robust, and may have a negative impact on patient compliance<sup>7</sup>. However, it is suggested that by enabling patients to collect all medicines at the same time (i.e. synchronising their ordering to no more than once a month), compliance is likely to improve.

A 2010 joint report by the York Health Economics Consortium and the School of Pharmacy at the University of London supports the use of 28-day prescribing intervals

where appropriate, but recognises that not all waste can be reduced and the cost of interventions required to reduce the waste may exceed the cost of the waste itself<sup>8</sup>. Reflecting data from this study in his presentation at the AWMSG 10-year conference in 2012, Rob Darracott of Pharmacy Voice stated “*The value of wasted medicines is approximately £300m a year (England), of which:*

- *£90m is at home*
- *£110m is returned to pharmacies*
- *£50m is disposed of by care homes”*

*50% of this waste is cost-effectively preventable, but significantly greater returns are available by better medicines use (£500m in just five therapy areas)”*.

The Welsh Government has stated its support for 28-day prescribing in its 2010 medication waste campaign, but qualifies this by prompting prescribers to consider other intervals (usually shorter) where clinically appropriate<sup>9</sup>.

Longer prescribing intervals have been called for both by patient groups<sup>10,11</sup> and some GPs<sup>12</sup>, citing patient inconvenience (and costs from travel and prescriptions [in England]), excess GP workload and dispensing costs as negative aspects of a 28-day policy. As generic drug costs fall, the cost of reimbursing for the act of dispensing (fees and allowances) may in some cases exceed the cost of the drugs. Repeat dispensing is increasingly being used and can provide a mechanism to address some of these concerns (see Section 6.0).

Longer prescribing intervals may be appropriate for some patients on stable doses of certain medicines (e.g. hormone replacement therapy [HRT], contraceptives and levothyroxine). A proportion of patients on levothyroxine remain on a stable dose for many years, suggesting that all prescriptions for this medicine could be based on longer prescribing intervals; however, many of these patients have other conditions, and may therefore have multiple medicines being prescribed. For example, a sample of three Welsh GP practices in 2012 noted that just 12–14% of levothyroxine patients were solely prescribed levothyroxine, the remainder receiving additional medicines on their repeat prescription. Prescribing medicines for the same patient with different intervals may result in the patient having to make as many, if not more, trips to the GP and pharmacy, or may lead to the patient having excess stocks of some medicines and not others. Prescribing according to manufacturers’ pack sizes (often a mix of both 28- and 30-day packs), together with multiples of “as required” medicines, such as analgesics, compound this effect.

Synchronising medication intervals is recommended by the National Prescribing Centre<sup>13</sup>, and there is an argument that synchronising the prescribing interval allows better medicines management, since clinicians can more easily monitor repeat request intervals<sup>14</sup>. It would seem logical to synchronise to the shorter interval, which may leave most patients still on a 28-day cycle. It is therefore also considered more appropriate to synchronise the medicines to the same quantity per month than to prescribe according to pack size, i.e. 28-day rather than 30-day. The synchronisation of small numbers of tablets on a monthly basis was considered impractical, certainly as a “prescriber” task. It was noted that it may be better for Community Pharmacists to undertake this level of synchronisation, although this in turn raises issues of communication back to the prescriber to record any changes. The development of repeat prescribing systems that encourage synchronised, once per month requests for long-term medication was strongly supported by AWPAG.

#### 4.0 PERFORMANCE RELATIVE TO 28-DAY TARGET

The AOF for NHS Wales sets out various measures by which NHS performance is benchmarked, and is reviewed by the Welsh Government on a yearly basis. In 2010–2011, targets were added to the Efficiency and Productivity section, alongside the established AWMSG National Prescribing Indicators, to encourage a move towards 28-day prescribing and increased use of the repeat dispensing service, available as part of the community pharmacy contractual framework.

The 28-day prescribing target requires prescribers to “*maintain performance levels within the range 25 to 31 quantity per prescription or demonstrate a movement towards 28 per script*”. The drug basket contains mostly cardiovascular medicines – all usually taken as once-daily doses – and excludes HRT, levothyroxine and other medicines likely to be prescribed for longer intervals (see Table 1). AWPAG concluded that the 28-day basket of medicines is appropriate as a means of identifying excessive use of 56- or 84-day prescribing.

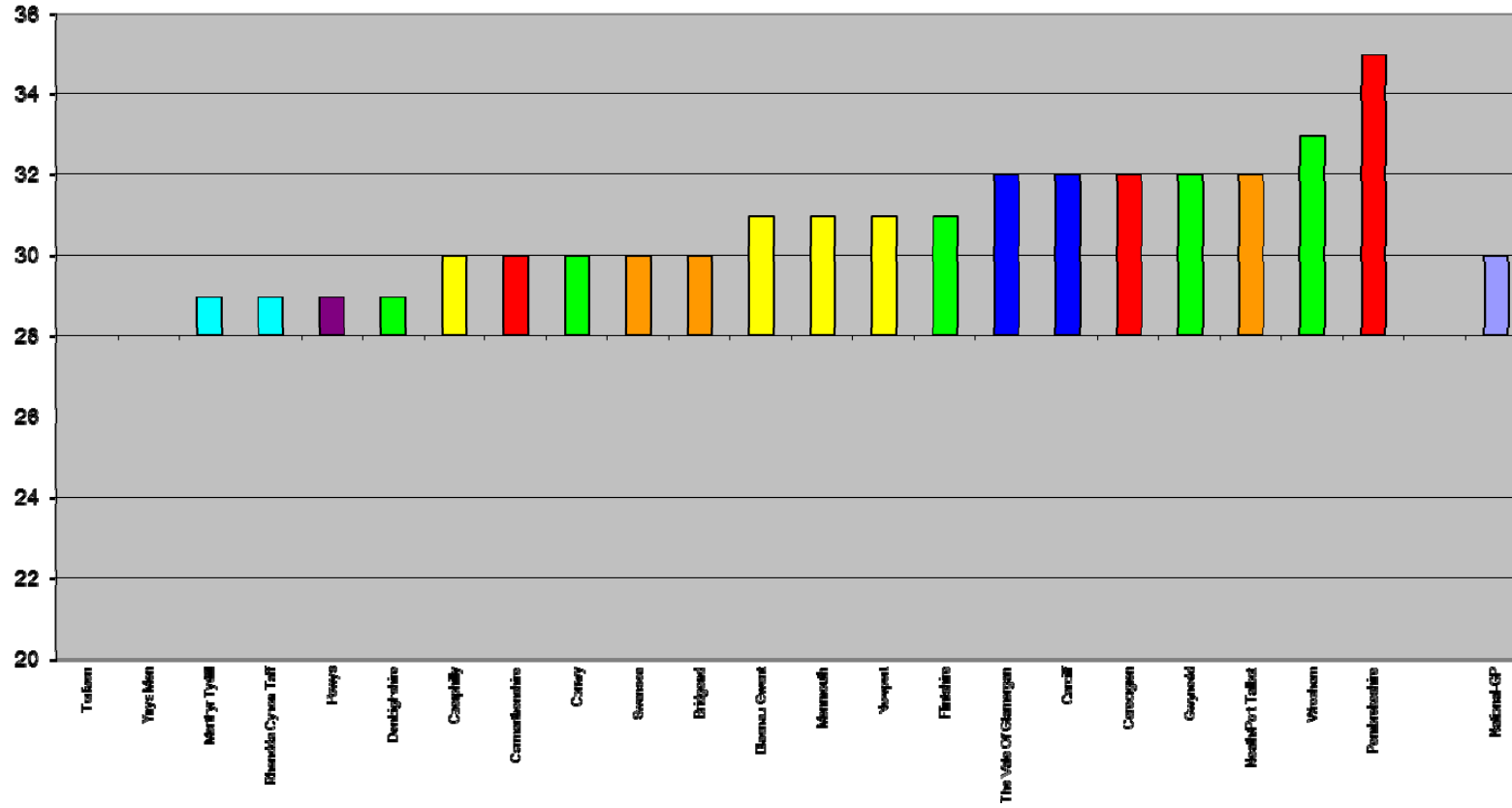
**Table 1. Generic medicines included in the 28-day basket**

Amlodipine	Clopidogrel	Furosemide	Omeprazole
Aspirin	Co-tenidone	Indapamide	Pantoprazole
Atenolol	Digoxin	Irbesartan	Perindopril
Atorvastatin	Diltiazem	Irbesartan/hydrochloroth	Pioglitazone
Bendroflumethiazide	Dilzem	Lacidipine	Pravastatin
Bezafibrate	Doxazosin	Lansoprazole	Rosuvastatin
Bisoprolol	Eprosartan	Lercanidipine	Simvastatin
Bumetanide	Esomeprazole	Lisinopril	Simvastatin/ezetimibe
Candesartan	Ezetimibe	Losartan	Telmisartan
Celiprolol	Fenofibrate	Montelukast	Telmisartan/hydrochloroth
Ciprofibrate	Fluvastatin	Nifedipine	Trandolapril
Citalopram	Fosinopril	Olmesartan	
NOTE: not all strengths or presentations are included			

Performance for the quarter ending 31 March 2012 ranges from 28 days in Torfaen and Ynys Mon to 35 days in Pembrokeshire (see Figure 1; please note that trend data to compare movement over time are not available).

Figure 1. March 2012 performance against 28-day target by locality (source: CASPA/NWIS).

28 Day Prescribing - March 2012 Qtr (Target = Maintain performance levels within the range 25 to 31 quantity per prescription or demonstrate a movement towards 28 per script. )



## 5.0 IMPACT ON PRESCRIBERS, DISPENSERS AND THE NHS

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Payments for dispensing contractors (community pharmacies, dispensing GPs and appliance contractors) are, to varying extents, based on reimbursement for the medicines/appliances supplied plus a dispensing fee. Tiered additional allowances are also paid to community pharmacies and appliance contractors based on numbers of prescription items dispensed each month. Because of this reimbursement model, it is difficult to quantify precisely the extra costs involved, should all prescriptions be written as 28 days or less, but there would undoubtedly be an increased cost to the NHS in terms of dispensing costs.

The move to 28-day prescribing has implications for the interpretation of prescribing data; in particular, the subsequent increase in the number of prescription items per capita. Wales has the highest number of prescriptions per person of all the UK nations (24, compared to 20.2 in Northern Ireland, 18.4 in England and 18.3 in Scotland)<sup>15</sup>. Comparing data from the 2011 Prescription Cost Analyses for each of these nations for a random group of medicines taken from the 28-day basket (see Appendix 1) shows that Wales has the lowest quantity of tablets per prescription at 32.3, with Northern Ireland and Scotland averaging almost 50 tablets per prescription compared to 37.6 in England. The prescribing interval is unlikely to be the sole reason for the difference in prescriptions per capita, with patient factors such as socioeconomic status, existing health needs and average age, plus prescriber pressures including commercial factors, peer pressure and patient expectations all influencing prescribing rates to some extent<sup>16–198</sup>.

Since 2008–2009, there has been an 11.4% increase in prescription items in Wales (although a slightly lower annual increase since the AOF target was launched). In that time, there has been a smaller increase (3.52%) in total spend (which includes drug costs), mostly driven by an increase in fees and allowances paid (average increase of 11.43%). Further details are in Appendix 2.

Increasing the number of prescriptions increases the costs of medication supply, as well as GP time in printing and signing the prescriptions. Longer prescribing intervals could reduce these costs to the NHS, but raises issues of synchronisation, outlined in Section 3.

## 6.0 REPEAT DISPENSING SYSTEM: BENEFITS, LIMITATIONS AND UPTAKE

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It has been argued that increased workload for GPs, mainly in signing prescriptions, is one reason for not reducing the prescribing interval to 28 days<sup>12</sup>. Since 2005, repeat dispensing (sometimes referred to as batch prescribing) has been available as an alternative to traditional repeat prescribing systems. Repeat dispensing is an essential service under the community pharmacy contractual framework. This states that pharmacies will dispense repeat prescriptions and store the documentation if required by the patient. They will also ensure that each repeat supply is required, and seek to ascertain that there is no reason why the patient should be referred back to their GP. Potential benefits of repeat dispensing are a reduced workload for GPs and practices, and increased patient convenience<sup>19</sup>.

Under this scheme, suitable patients on appropriate repeat medication can have up to 12 repeats authorised (the GP signs only the authorising repeat dispensing prescription; the repeat dispensing forms are not signed), potentially reducing the number of prescriptions that need to be signed from 12 to 1. GPs may retain closer clinical oversight by authorising fewer repeats (6 instead of 12).



Evidence for the benefit of this service is poor in terms of impact on GPs; however, in 2002, a Cabinet Office report estimated “*up to 330 million (80%) of all repeat prescriptions could be replaced with repeat dispensing over time. This could yield a saving of up to 2.7 million hours of GP and practice time*”<sup>20</sup>. For a community pharmacy, a 2006 Manchester University report estimated a time saving of 25 seconds for the processing and dispensing of a four-item repeat dispensing batch prescription, compared to a non-repeat dispensing prescription. Time taken to hand out a repeat dispensing prescription was an average 6 seconds longer, indicating that pharmacists took more time talking to patients. The report also supports the theory that repeat dispensing saves the NHS money by increasing the amounts of “not dispensed” items (mean saving of 56.89 pence per repeat dispensing script, compared to 0.77 pence per non-repeat dispensing script)<sup>21</sup>.

Uptake of the repeat dispensing scheme depends on initiation by the GP. Technical issues in aligning the printer templates for the repeat dispensing scripts with the prescription stationery initially hampered the roll out; however other anecdotal reasons for the lack of uptake since are included in Table 2.

Most health boards have designed support packs for repeat dispensing, based on the original NHS Wales document<sup>22</sup>, and have also helped interested practices to set the scheme up. Such packs include good practice tips, such as what cohorts of patients to offer the service to. Uptake is inconsistent across health boards (see Appendix 3 for Torfaen data) and within Wales. In April 2012, 182 of 562 practices (32.4%) were issuing some repeat dispensing forms. Resistance to uptake of the scheme remains, at least in some areas<sup>23</sup>.

In late 2012, the Steering Group on Improving the Use of Medicines (for better outcomes and reduced waste) published their action plan<sup>3</sup>. Repeat dispensing featured as part of the targeted support for patients in primary and community care, with the following actions proposed:

- Develop a repeat dispensing engagement plan for local NHS bodies and GPs to highlight the benefits to all. The Steering Group believes there is a key role for the Royal Pharmaceutical Society and Royal College of General Practitioners to work collaboratively to develop this.
- An electronic repeat dispensing solution will remove one barrier to uptake, but practices should not wait for this as many practices have successfully implemented repeat dispensing in its current form.
- Software companies should be encouraged to resolve any barriers to repeat dispensing faced by non-medical prescribers.

A fourth recommendation (to benchmark practices by monitoring the proportion of prescriptions issued as Repeat Dispensing) is already in place in Wales.

Some primary care trusts in England now have rates of repeat dispensing in excess of 25%.

A robust evaluation of the repeat dispensing scheme in Wales would ensure that resources are being spent appropriately and will guide a decision on the future of the service.

**Table 2. Anecdotal reasons for lack of repeat dispensing uptake**

Perceived barrier	Potential solution
Difficulties in setting up the system and migrating patients across; in particular, gaining patients' signed consent, difficulties in educating patients about the "new" system	<p>Collaboration between the pharmacists and GP practice to:</p> <ul style="list-style-type: none"> <li>• identify suitable patients</li> <li>• inform patients about how the system works</li> </ul> <p>Uptake will increase if there is a system for education and consent agreed between the pharmacy and practice.</p> <p>The community pharmacist is best placed to provide information and consent, in discussion with the practice. Repeat dispensing provides continuity between patient and pharmacy.</p>
Practical difficulties maintaining repeat dispensing for patients and co-ordinating chronic disease reviews with repeat dispensing scripts	Practice recalls/medication reviews to be synchronised with repeat dispensing where possible.
Continued motivation from all practice members until repeat dispensing is perceived as a "normal default procedure"	Careful patient selection initially, eg levothyroxine and stabilised people on antihypertensives, can increase confidence
Perceived lack of prescribing control – patients bypassing the practice for their repeats	<p>Where active surveillance is appropriate, repeat dispensing should not be undertaken.</p> <p>Patients can be provided one-month scripts if therapy is under active review, and repeat dispensing restarted once the patient is stabilised.</p> <p>After undertaking a medication review, practices may decide to re-authorise medicines for 12 months but only issue 6-month repeat dispensing. This will allow a brief review of the record before issuing the remaining batch.</p>
Difficulty in communicating prescription changes to the community pharmacy (ensuring that medicines no longer authorised do not get dispensed), need to reprint all items on the repeat dispensing script should one item change (may indicate poor selection of patients/medication).	<p>Practices encouraged to start repeat dispensing with the most stable patients (as above).</p> <p>It is essential that patients on repeat dispensing are clearly identified at the point of prescribing, and that medicine changes are documented and communicated with the community pharmacist.</p>

## 7.0 MEDICATION REVIEW

Regardless of the method for repeating medicine supply, good medicines management remains key to ensuring patients are kept safe and NHS resources are used wisely. Effective medication review processes, preferably involving the patient so that compliance and patient wishes can be taken into account, are needed. Such reviews should not only identify whether a medicine is clinically appropriate for the presenting condition, but also whether it is appropriate for the patient, considering any other conditions they may have, and whether there is over/under use (which is not always possible from the prescribing history). A gold-standard medication review is outlined in the AWMMSG guidance document "Warfarin Monitoring"<sup>24</sup>.

## 8.0 SUMMARY

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The evidence regarding whether 28-day prescribing in itself reduces medication waste has some limitations; however, it should be stressed that most NHS guidance calls for the appropriate use of a 28-day prescribing interval, reducing or increasing the interval as clinically necessary. There are potential additional benefits in terms of facilitating medication review and medicines management.

The AOF target highlights those practices where the majority of prescribing is significantly longer than the 28-day interval, which should apply *in most cases*. The basket of drugs from which the target is calculated includes medicines normally taken as once-daily doses (for ease of calculation) and, in common with other indicators, allows practices and prescribing advisors to engage in a conversation as to why a practice is prescribing in a certain way – the answer to this *might* justify a practice lying outside of the “norm”.

According to NHS Eastern and Coastal Kent “A 28-day repeat prescribing interval is recognised by the NHS as making the best possible balance between **patient convenience, good medical practice and minimal drug wastage**.”<sup>25</sup>

This message has been echoed by most NHS bodies and this review suggests that it remains appropriate, although this is based on a consensus view rather than robust evidence. The 28-day indicator is appropriate as a means of identifying excessive use of the 56- or 84-day prescribing interval. Whilst a 28-day prescribing interval is recommended, discretion is required by the prescriber to avoid excessively applying it to all patients or medicines. GPs concerned with increased workload should discuss the options for repeat dispensing with their health board and community pharmacies.

Health boards and prescribers could ideally adopt a flexible approach for suitable patients, whereby a shorter interval (7–14 days) is used for initiating a medicine to assess tolerability and compliance, or is recommended by the BNF or regulatory bodies. This should be coupled with a rigorous and effective medication review process, and, where possible, a system which promotes synchronised, once per month requests for long-term medication.

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APPENDIX 1: Prescribing cost analyses for 2011

Data from prescribing cost analyses for 2011: for illustrative purposes only, generic prescribing unless otherwise indicated

Drug / strength	England			Northern Ireland			Scotland			Wales		
	Items (i)	quantity (q)	q/i	Items (i)	quantity (q)	q/i	Items (i)	quantity (q)	q/i	Items (i)	quantity (q)	q/i
Amlodipine 5mg	11,970,148	430,743,305	35.98	265128	12216505	46.08	915,372	42,435,352	46.36	933,099	28,465,314	30.51
Amlodipine 10mg	7,426,126	267,218,570	35.98	139022	6365134	45.79	544,432	25,534,278	46.90	526,852	15,970,630	30.31
Aspirin 75mg disp	22,790,770	766,662,044	33.64	310652	13921185	44.81	2,364,814	111,598,636	47.19	2,106,957	63,439,503	30.11
Atenolol 100mg	1,731,273	63,876,809	36.90	28238	1412738	50.03	209,905	10,167,648	48.44	125,919	3,994,987	31.73
Atenolol 25mg	3,843,486	140,302,975	36.50	32972	1738656	52.73	452,380	24,555,506	54.28	248,907	7,826,404	31.44
Atenolol 50mg	6,529,011	243,562,165	37.30	71979	3694666	51.33	746,247	38,548,515	51.66	462,863	14,790,948	31.96
Atorvastatin 10mg (lipitor)	2,586,156	92,368,614	35.72	71629	3416530	47.70	207,577	9,487,333	45.71	218,642	6,668,397	30.50
Atorvastatin 20mg (lipitor)	3,143,837	111,390,663	35.43	105127	4969652	47.27	294,978	13,725,278	46.53	315,217	9,518,178	30.20
Atorvastatin 40mg (lipitor)	4,103,250	138,927,016	33.86	142754	6449858	45.18	441,345	20,325,711	46.05	330,975	9,784,098	29.56
Bendroflumethiazide 2.5mg	1,795,741	67,277,456	37.47	487379	23721222	48.67	1,893,828	92,303,030	48.74	1,477,820	47,188,203	31.93
Clopidogrel 75mg	4,155,074	120,777,321	29.07	181637	7558570	41.61	322,571	14,163,808	43.91	262,108	7,167,831	27.35
Ezetimibe 10mg tab (ezetrol)	2,221,687	76,130,426	34.27	55737	2536931	45.52	199,530	9,032,525	45.27	168,045	4,996,955	29.74
Lacidipine 2mg	183,942	7,133,050	38.78	1169	60653	51.88	6,810	320,643	47.08	15,748	519,876	33.01
Lacidipine 4mg	262,666	9,867,166	37.57	1642	80791	49.20	10,521	479,170	45.54	22,468	727,573	32.38
Lisinopril 10mg	3,013,251	113,546,320	37.68	64447	3182699	49.38	299,936	14,727,232	49.10	253,050	8,110,674	32.05
Lisinopril 2.5mg	1,132,952	38,513,998	33.99	20380	905047	44.41	106,068	4,795,863	45.21	92,295	2,770,513	30.02
Lisinopril 20mg	3,455,761	146,552,747	42.41	56343	3056969	54.26	349,522	20,090,867	57.48	286,316	10,508,220	36.70
Lisinopril 5mg	2,322,073	85,102,088	36.65	45395	2180815	48.04	224,090	10,672,077	47.62	192,148	6,006,583	31.26
Losartan 25mg	802,148	28,110,069	35.04	10551	485213	45.99	58,596	2,680,481	45.75	57,637	1,721,398	29.87
Losartan 50mg	1,958,619	74,853,188	38.22	32964	1651719	50.11	161,311	7,997,559	49.58	136,898	4,412,195	32.23
Losartan 100mg	1,682,947	62,339,888	37.04	27012	1315144	48.69	150,778	7,201,239	47.76	123,557	3,862,531	31.26
Simvastatin 10mg	2,436,835	85,927,459	35.26	40875	1908258	46.69	134,579	6,095,309	45.29	170,804	5,122,717	29.99
Simvastatin 20mg	10,463,914	371,353,335	35.49	146046	6733845	46.11	674,214	31,466,044	46.67	863,441	25,905,676	30.00
Simvastatin 40mg	26,918,203	931,047,237	34.59	620034	27818554	44.87	2,074,808	95,034,295	45.80	1,950,904	58,081,713	29.77
<b>Average qty/script</b>			<b>37.60</b>			<b>49.84</b>			<b>49.74</b>			<b>32.34</b>

References for Prescription Cost Analyses:

- England <http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/prescriptions/prescription-cost-analysis-england--2011>
- Northern Ireland <http://www.hscbusiness.hscni.net/services/2266.htm>
- Scotland <http://isdscotland.org/Health-Topics/Prescribing-and-Medicines/Community-Dispensing/Prescription-Cost-Analysis/>
- Wales <http://wales.gov.uk/topics/statistics/theme/health/primary-care/prescribing/?lang=en>

## APPENDIX 2: Dispensing account analysis

## DISPENSING ACCOUNT

nb excludes scripts dispensed in England

Number of prescription items						
Contractor Type	April 2008 To March 2009 Items	April 2009 To March 2010 Items	April 2010 To March 2011 Items	April 2011 To March 2012 Items	% change in items 08/09 to 11/12	net change items 08/09 to 11/12
Chemists	60619833	63120942	65162761	67597571	11.5%	6,977,738
Appliance Contractors	149489	163837	185279	195991	31.1%	46,502
Dispensing Doctors	4029626	4154014	4279339	4362126	8.3%	332,500
Personal Admin	767653	838102	856031	867521	13.0%	99,868
Total	65566601	68276895	70483410	73023209	11.4%	7,456,608
year on year increase		4.13%	3.23%	3.60%		

Increase in total spend						
Contractor Type	April 2008 To March 2009 spend	April 2009 To March 2010 spend	April 2010 To March 2011 spend	April 2011 To March 2012 spend	% change 08/09 to 11/12	net change spend 08/09 to 11/12
Chemists	£607,016,070.00	£618,739,515.00	£629,040,742.00	£629,075,891.00	3.63%	£22,059,821.00
Appliance Contractors	£11,432,664.00	£12,258,205.00	£13,638,958.00	£15,408,388.00	34.78%	£3,975,724.00
Dispensing Doctors	£39,286,818.00	£38,638,439.00	£38,551,506.00	£37,497,393.00	-4.55%	£-1,789,425.00
Personal Admin	£12,694,809.00	£12,238,246.00	£12,232,601.00	£12,080,712.00	-4.84%	£-614,097.00
Total	£670,430,361.00	£681,874,405.00	£693,463,806.00	£694,062,383.00	3.52%	£23,632,022.00

spend includes:

Basic Price SDR	On Cost
Basic Price ZD	Addition Fee
Discount	Dispensing Fees
Container Allowance	Oxygen Fees
Professional Fees	VAT (excl chemists)
Expensive Fees	Adjustments
Professional Payment	Elastic Hosiery

Increases in fees						
Contractor Type	April 2008 to March 2009 fees	April 2009 To March 2010 fees	April 2010 To March 2011 fees	April 2011 To March 2012 fees	% change fees 08/09 to 11/12	net change fees 08/09 to 11/12
Chemists	£122,659,454.00	£129,453,174.00	£133,837,440.00	£138,518,366.00	12.93%	£15,858,912.00
Appliance Contractors	£1,449,821.00	£1,596,252.00	£1,041,328.00	£1,156,432.00	-20.24%	£-293,389.00
Dispensing Doctors	£8,662,719.00	£8,532,201.00	£8,384,063.00	£8,510,111.00	-1.76%	£-152,608.00
Personal Admin	£1,912,267.00	£1,880,958.00	£1,885,034.00	£1,891,751.00	-1.07%	£-20,516.00
Total	£134,684,261.00	£141,462,585.00	£145,147,865.00	£150,076,660.00	11.43%	£15,392,399.00

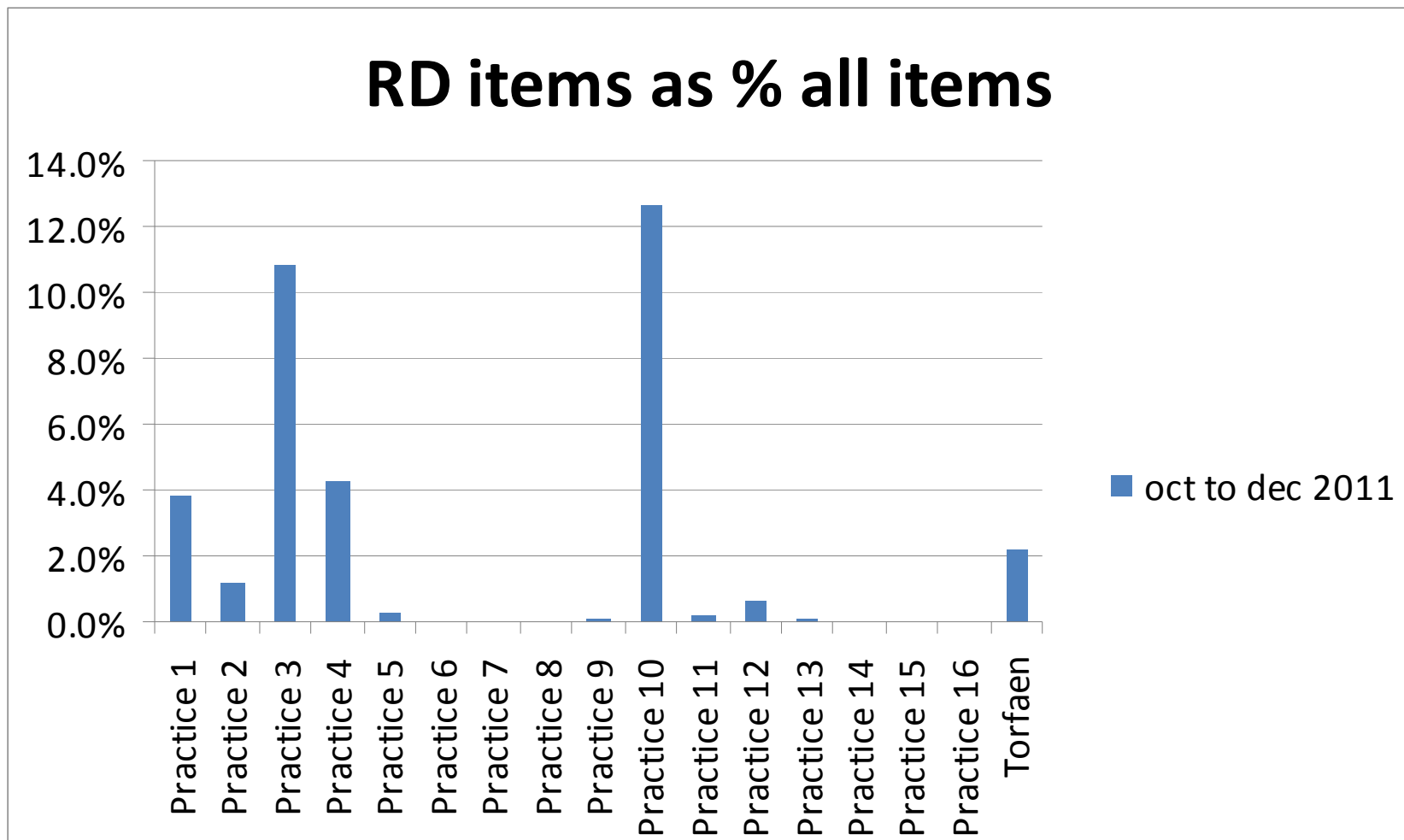
nb appliance contractor fees included on cost allowance in 08/09 and 09/10

fees include

Container Allowance	On Cost
Professional Fees	Addition Fee
Expensive Fees	Dispensing Fees
Professional Payment	Oxygen Fees

Data taken from NHS Dispensing Account, access restricted to NHS staff

APPENDIX 3: Torfaen repeat dispensing data





This report has been prepared by the All Wales Prescribing Advisory Group (AWPAG) with support from the All Wales Therapeutics and Toxicology Centre (AWTTC), and has subsequently been endorsed by the All Wales Medicines Strategy Group (AWMSG). Please direct any queries to AWTTC:

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